OSAB | *July 2016* | *Version 6*

Oxfordshire Safeguarding Adults Board 2015-16 Annual Report

Foreword

This is the first report of the Safeguarding Adult Board since the introduction of the Care Act. This report demonstrates the achievements in 2015 -16 which help to build a safer Oxfordshire. It also outlines the key priorities for 2016-17. During the year the independent chair, Sarah Mitchell, stepped down in order to focus on her substantive role with the Local Government Association. I would like to take this opportunity to thank Sarah for the huge contribution she made to the Board during her time in Oxfordshire. We wish her well in her future work.

The report contains contributions from partner organisations involved in safeguarding adults. Following a peer review the Board has reviewed its governance and its structure. There is a culture of trust and mutual understanding developing through greater partnership working as the Oxfordshire Board matures. This work has included joining the training subgroups of the Children's and Adults Safeguarding Boards. This should enhance an understanding of safeguarding across all age groups.

Adult abuse can take many forms; hate crimes, neglect and abuse which can be physical, psychological and financial. Through its partner organisations, the Board will create a culture of transparency which does not tolerate abuse and which takes all concerns seriously. We all have a responsibility to safeguard vulnerable adults and the Board will continue to oversee this work in 2016-17.

Sula Wiltshire
Interim Chair of the Oxfordshire Safeguarding Adults Board
Director of Quality/Lead Nurse, Oxfordshire Clinical Commissioning Group

What is the framework for safeguarding adults?
The Care Act 2014 – General Overview

The Care Act 2014 was introduced in April 2015. It is the most significant change in social care law in 60 years. The legislation sets out how care and support needs should be met. It introduces the right to an assessment for anyone in need of support, including carers and self-funders.

The Act sets out a legal framework for how adults at risk of abuse or neglect should be protected.

The safeguarding duties of local authorities are to:

- lead a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens
- make enquiries, or request others to make them, when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed (commonly called a Section 42 enquiry)
- establish Safeguarding Adults Boards, including the local authority, NHS and police, which will develop, share and implement a joint safeguarding strategy
- carry out Safeguarding Adults Reviews when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them
- arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

What is the framework for safeguarding adults?
The Care Act 2014 – Safeguarding Adults Boards

There has been a Safeguarding Adults Board (SAB) in place in Oxfordshire since 2009. The Care Act gave the SAB a statutory footing for the first time.

The Board has three main duties under the Care Act. The Board must:

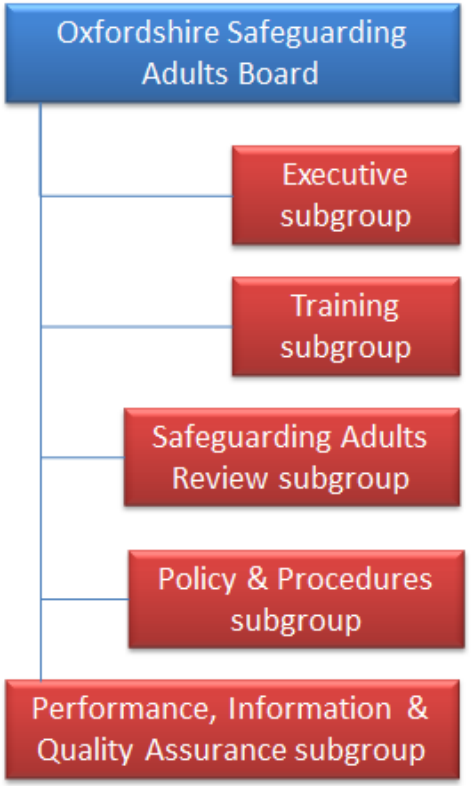
- publish a strategic plan for each financial year.
- publish an annual report detailing what the SAB has done during the year.
- conduct any safeguarding adults review in accordance with Section 44 of the Act.

In order to meet these objectives the board should:

- agree and review multi-agency safeguarding adults policy and procedure for protecting vulnerable adults, taking into account statutory requirements, national guidance and local learning from Safeguarding Adult Reviews.
- monitor incidents of abuse and neglect, reviews trends and regularly evaluate how agencies and providers safeguard vulnerable adults. This should be done by introducing rigorous quality assurance and scrutiny systems across partner agencies.
- agree case review protocol and review and learn from situations where safeguarding arrangements may have been inadequate.
- maintain a programme of training and development on safeguarding vulnerable adults for staff across agencies in the statutory, independent provider and voluntary sectors.
- promote public awareness of safeguarding as an issue for all citizens and engage the wider community in helping to prevent abuse and neglect and to report where they have concerns.

What is the framework for safeguarding adults?
Safeguarding Adults Board – how we operate

The Board is supported by five subgroups (see diagram).



Frequency of meetings

The Full Board, the Executive Group, the Performance, Information & Quality Assurance group (PIQA) and the Training subgroup meet quarterly. The Policy & Procedures subgroup meet bi-monthly and the Safeguarding Adults Review (SAR) subgroup meet monthly.

Membership

The Care Act requires that the Board includes representatives from the Local Authority, Police and the Clinical Commissioning Group. The Board membership in Oxfordshire also includes representatives from other agencies, such as the District Councils, both Probation services and the voluntary sector in order to further strengthen partnership working and develop the role and functions of the Board.

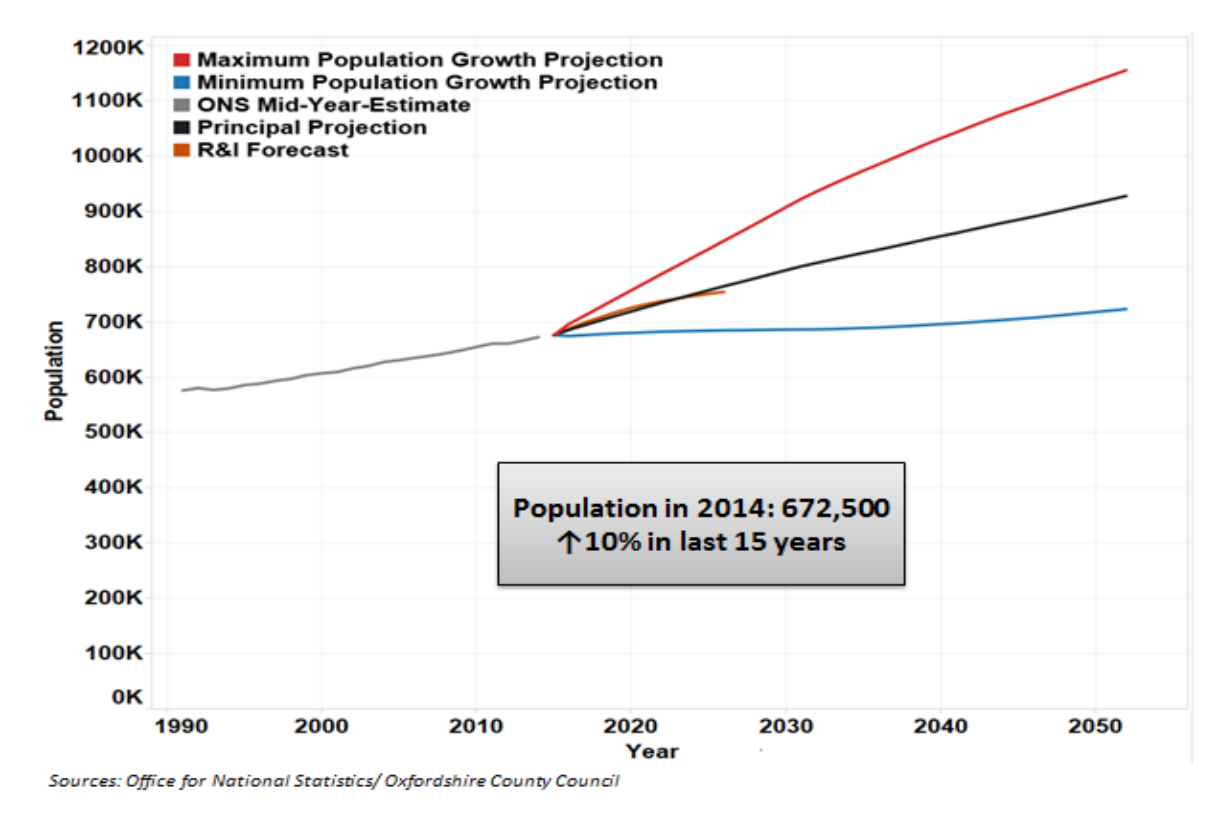
Links with other partnership groups

During 2015-16 a working protocol was developed, setting out how the various multi-agency partnerships work together to safeguard and promote the welfare of Oxfordshire residents, such as The Oxfordshire Health and Wellbeing Board and the Oxfordshire Safeguarding Children Board.

The protocol is waiting on final sign off by all partners and will be active from from summer 2016.

Who are we protecting?
The general population

Oxfordshire is home to some 672,500 people. The population has grown by 10% in the last 15 years and a further increase of 13% is predicted over the next 10 years. Oxfordshire County Council's latest population forecast shows the county's population increasing by 86,000 (13%) from 2014 to 2026.

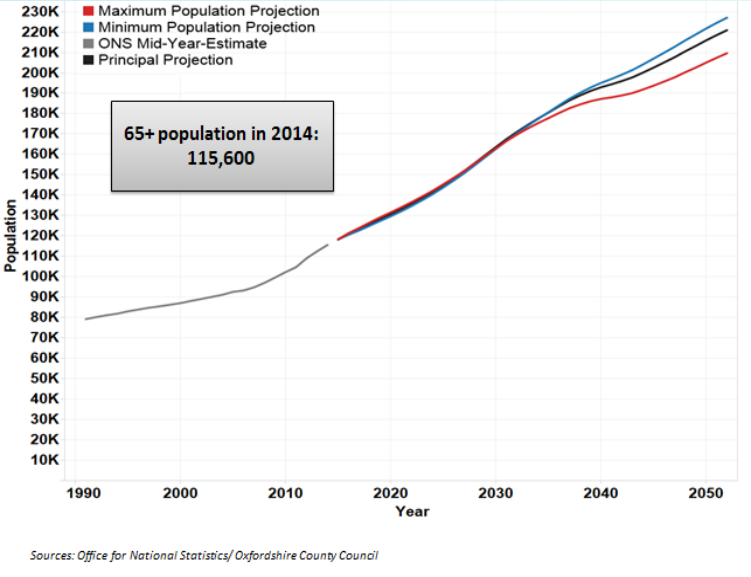


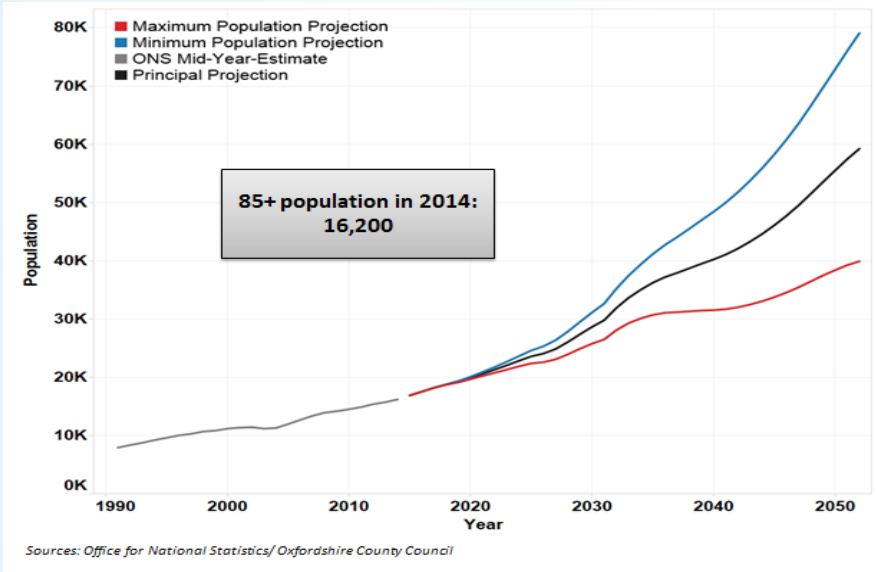
Sources: Office for National Statistics/ Oxfordshire County Council

Who are we protecting?
An aging population

There were an estimated 415,800 adults aged 18-64 in Oxfordshire in 2014, representing an increase of 0.9% since 2011. In 2014 there were an estimated 115,600 people aged 65 and over, representing an increase of 11.4% since 2011.

Within this group, the number of people aged 85 and over was estimated to have increased by 10.3%, to 16,200. In 2014 those aged 65 and over made up an estimated 17.2% of the county's population (up from 15.9% in 2011); 85 and overs made up 2.4% (up from 2.2% in 2011). These proportions were slightly lower than in the South East (where 65 and overs comprised 18.6% of the population and 85 and overs 2.6%). They were similar to England overall (17.6% and 2.3%, respectively).





Who are we protecting?
Life Expectancy

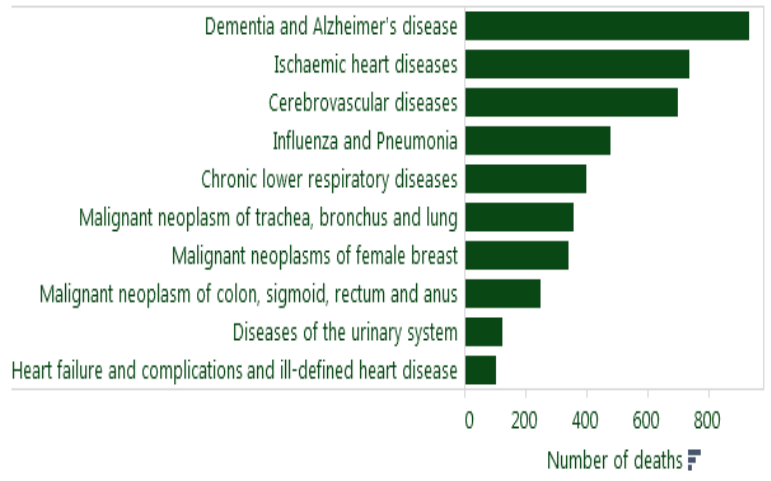
The Office for National Statistics publishes three-year rolling estimates of healthy life expectancy (the number of years of life a person spends in good health) at national, regional and county levels.

Nationally, overall life expectancy has been increasing faster than healthy life expectancy in recent years; this means people may have more years living in ill health in the future.

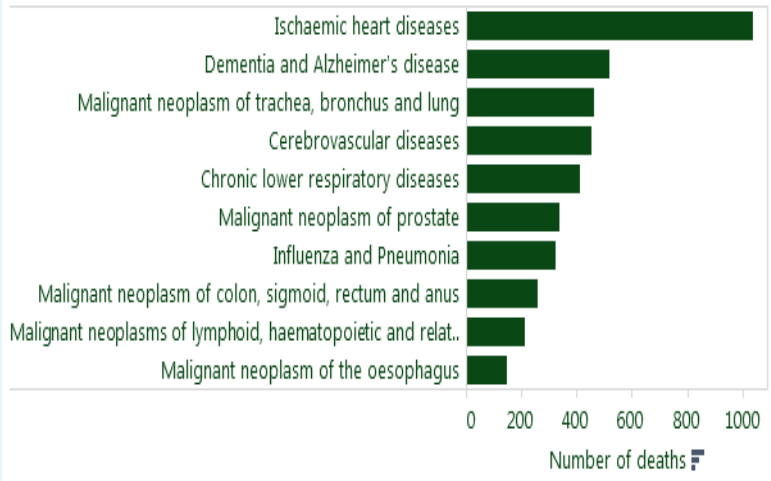
Healthy life expectancy in Oxfordshire is above the national average: for the period 2011- 2013 the average healthy life expectancy for a male born in England was 63.3; for a female it was 63.9.

Oxfordshire is similar to the national picture in terms of leading causes of death in males and females.

Female



Male



Who are we protecting?
Vulnerable Groups

At the time of the 2011 Census, 89,800 people in Oxfordshire said they were limited in their daily activities. This is nearly one in seven people in the county (13.7%). 94.3% of these were living at home. On average, Oxfordshire's people were less limited in their daily activities than in the wider South East, where 15.7% reported this. Levels across England were higher again, with 17.6% saying they were limited. Around two fifths of the people in Oxfordshire who were limited in their daily activities, said they were limited a lot (numbering 37,600, 5.8% of the county's population). Again, this was lower than the proportions seen in the South East (6.9%) and England (8.3%).

Nationally, people with serious mental illnesses and/or learning disability have higher mortality and morbidity rates and die on average 10 to 20 years younger than the general population.

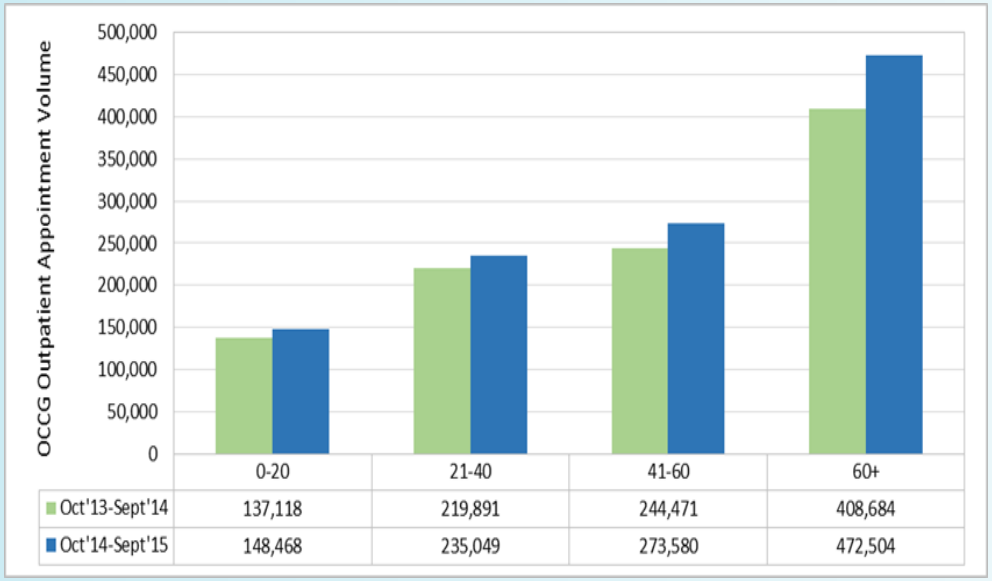
Physical Disability Estimated 30,000 people living with a physical disability in Oxfordshire.	**Autistic Spectrum Disorder** Estimated 6,850 people living with Autistic Spectrum Disorder in the county.
Learning Disability Estimated 2,600 living with a Learning Disability in the county, which is in line with national and regional trends	**Mental Health** Depression & anxiety - 42,600 people living with these conditions, which is a 15% increase since 2013-14. Significant diagnosed mental health disorders – Affects an estimated 5,600 people in the county, a 5% increase since 2013-14. This is in line with national figures

What are our services doing?
Health Services

As with social care services, there is increasing pressure on health services in Oxfordshire. The 74 GP practices in area have 720,029 registered patients.

In the year to end of Sep 2015 there was a:

- 10.6% rise in outpatient appointments
- 1.4% rise in A&E attendances
- 2.2% rise in emergency inpatient admissions



	0-20	21-40	41-60	60+
Oct'13-Sept'14	137,118	219,891	244,471	408,684
Oct'14-Sept'15	148,468	235,049	273,580	472,504

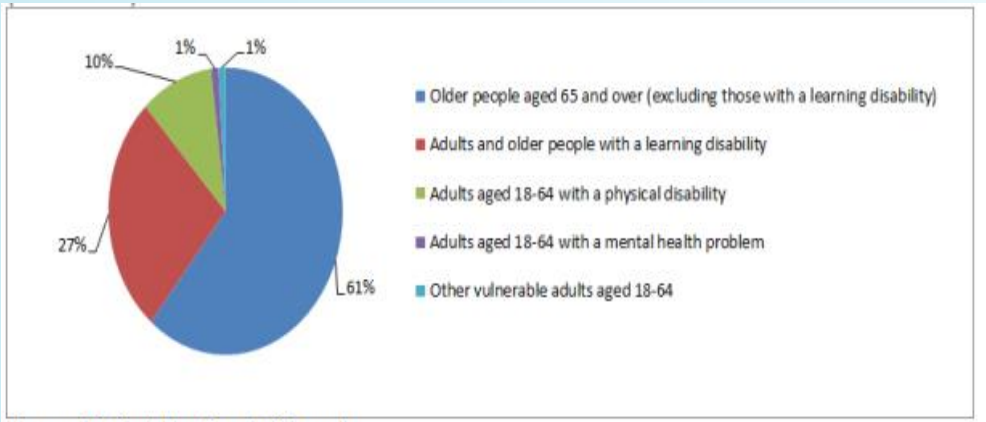
Mental Health Services

In 2014-15 slightly over 10,000 Oxfordshire residents were referred to Oxford Health mental health services and seen at least once. This represents a fall of around a thousand since 2013-14, but is similar to the number in the previous two years. Since some patients were referred more than once during the year, the number of referrals was around 13,500. This number is down on the previous three years.

Almost half of the referrals were for Oxfordshire Adult Mental Health Services (47%). One in five were to the Oxfordshire Older Adult Mental Health Services (20%). Significant minorities of referrals were for Oxfordshire Psychological Services (7%) and Eating Disorders Oxfordshire (2%). The remaining referrals were to other mental health services.

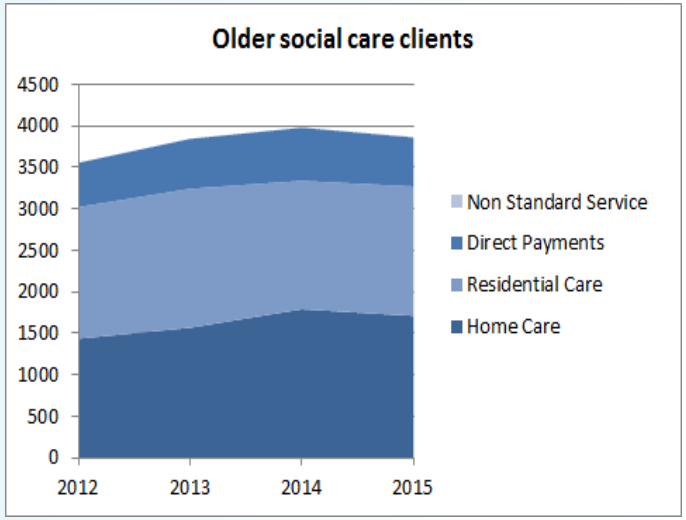
What are our services doing?
Adult Social Care

At the end of March 2015 there were 6,494 adults in Oxfordshire receiving long-term social care funded by the county council. A breakdown by client group is presented in the figure below. This shows that the majority of Oxfordshire's social care clients are older people, aged 65 and over.



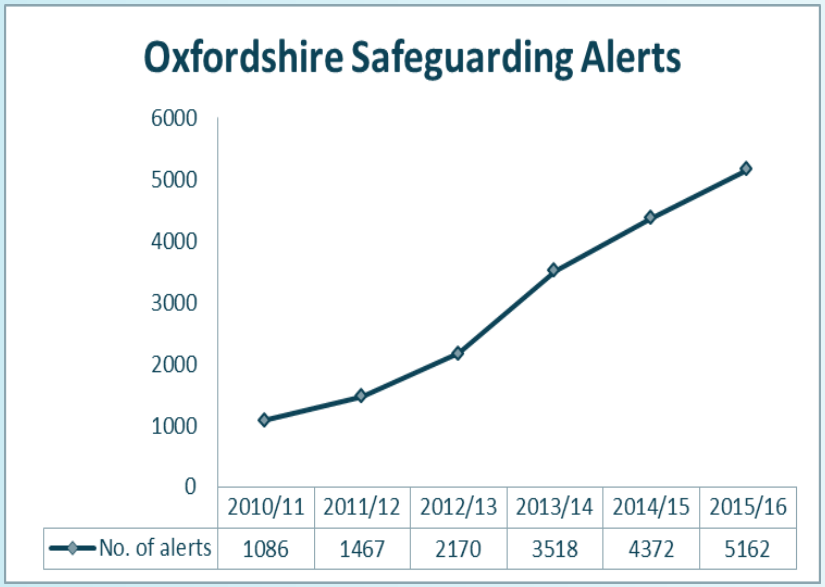
Source: Oxfordshire County Council

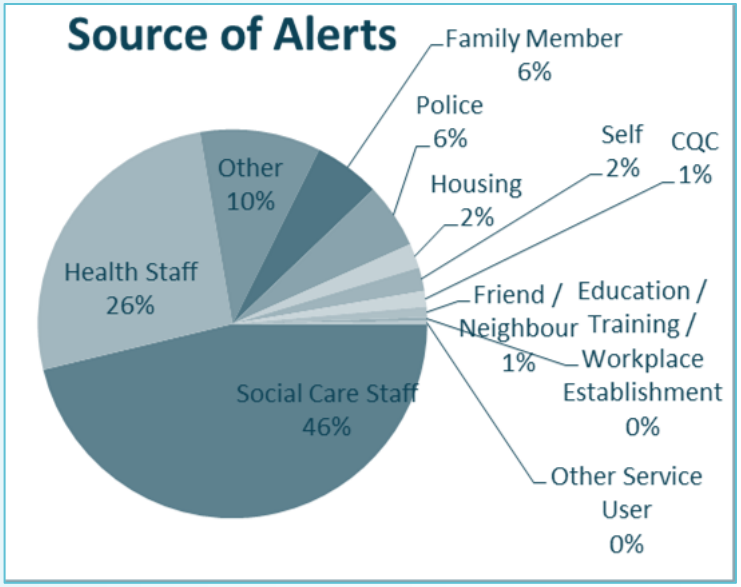
The majority of adult social care users are supported at home rather than in a care home.



How well are we doing?

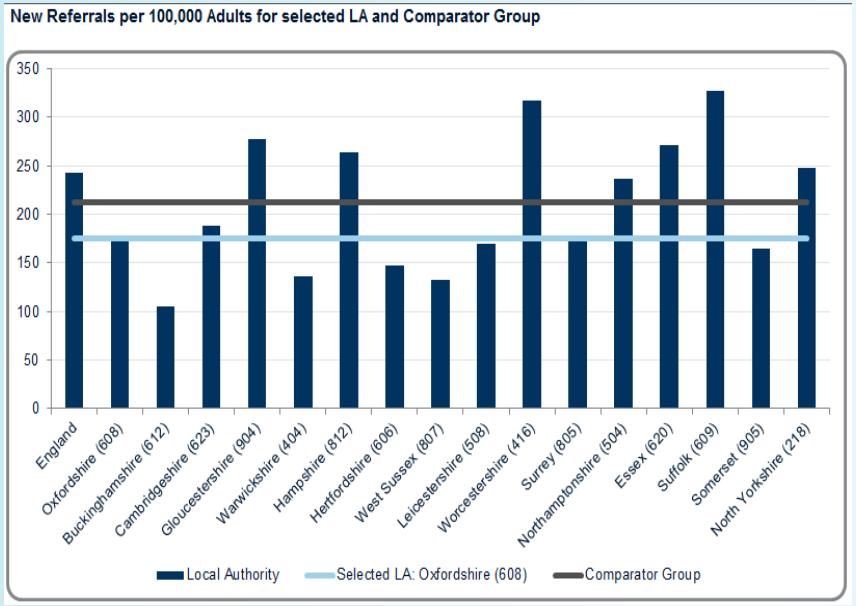
There was an 18% increase in safeguarding alerts (an alert is when someone contacts social services with a safeguarding concern over an adult) in 2014-15, increasing from 4,372 in the previous year to 5,162. This figure has consistently increased over the last five years and the number of alerts is now nearly five times the level in 2010/11. Nearly half the alerts come direct from care providers, a quarter from health with one in ten from family and friends or the person themselves. This demonstrates how the safeguarding of adults with care and support needs is everyone's business. More abuse took place in the home than in any other setting.





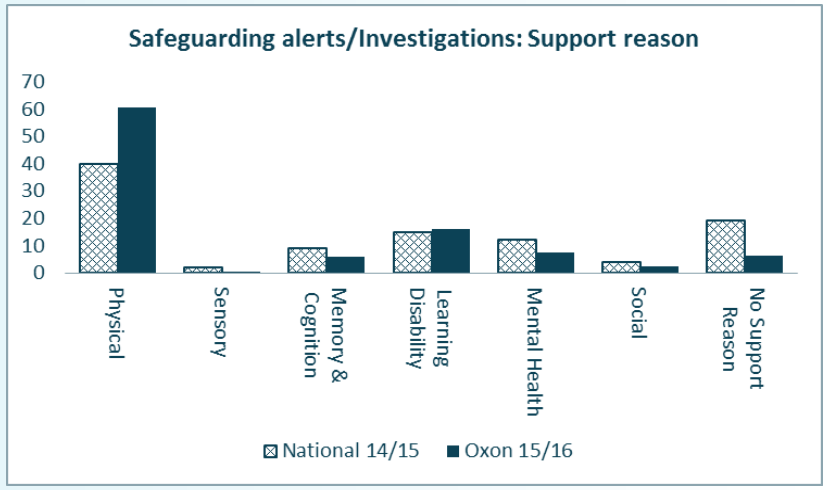
How well are we doing?

In 2014-15 there were 934 referrals - alerts where further work was needed. This equates to 176 per 100,000 population. This was slightly below the level of similar authorities (average 213) and the England average of 243. In 2015-16 there were 1542 enquiries. This is a 65% increase in cases that required further investigation. This equates to 291 enquiries per 100,000 population, which is above both the national rate for 2014-15 and that of similar authorities.



The pattern of support needs in Oxfordshire of people referred to safeguarding is slightly different from the national pattern. More people are in need of physical support , but fewer people who need support for mental health issues. This may in part be explained by high rates of recording of support reasons locally

In Oxfordshire in 2014-15 over half the risk is associated with the care provider. This dropped in 15-16 to 44% but is still above the national level and that of similar authorities.



How well are we doing?

Referrals / investigations

Section 42 of the Care Act places a duty on local authorities to make enquiries, or cause other agencies to do so, to establish whether action is needed to prevent abuse, harm, neglect, or self-neglect to an adult at risk of harm. This change means there is no directly comparable data on section 42 enquiries. However, we previously reported on safeguarding referrals, that is alerts where further work was needed.

During 2013-14, 3.75% of people supported within the safeguarding adults procedures were from **minority** ethnic communities. According to the 2011 census, 9.15% of Oxfordshire's residents come from non-white backgrounds. This discrepancy is largely explained by the difference between age groups. Whereas the proportion of adults under 65 from non-white backgrounds is 9.44% the proportion of adults over 65 from non-white backgrounds is 2.25%.

Ethnicity	No	%
White	1331	96
Mixed	5	0
Asian/Asian British	28	2
Black/African/Caribbean /Black British	17	1
Other Ethnic Group	6	0
Total recorded	1387	
Not known or not declared	155	11
Total	1542	

Last year in Oxfordshire 30% of all alerts progressed to a formal section 42 safeguarding enquiry. There were 1,542 such enquiries. 96% of referrals where an ethnicity was recorded were of white people; 2% were Asian or Asian British and 1% Black, African, Caribbean or Black British.

How well are we doing?

The Care Act amended the type of risks that should be reported on safeguarding cases. This means that direct comparisons are not possible with last year or other authorities. The first table below looks at only the categories of abuse which have not been changed, and the second table at all the categories including the new categories in the Care Act.

Comparing categories of abuse with national figures*

	National 14-15	Oxon 15-16
Physical	27%	24%
Sexual	5%	4%
Psychological/ Emotional	15%	13%
Financial and Material	17%	13%
Neglect and Omission	32%	46%
Discriminatory	1%	0%
Institutional	3%	1%

*The Care Act introduced new categories of abuse so at the time of writing there is no comparative national data from 2014-15 for the new categories. Self-neglect, modern slavery and sexual exploitation data has only been captured since Nov 2015.

Oxfordshire categories of abuse - including new care act categories for 15-16

Physical abuse	**21%**
Sexual abuse	3%
Psychological abuse	12%
Financial abuse	11%
Discriminatory abuse	0%
Organisational Abuse	1%
Neglect and acts of omission	41%
Domestic abuse	1%
Sexual exploitation	0%
Modern Slavery	0%
Self Neglect	10%

How have we responded to the national changes?

In the summer of 2015, OSAB took part in the Local Government Association's peer challenge process. The peer challenge for adults safeguarding is a constructive and supportive process with the central aims of:

- helping a council and its partners to assess its current achievements
- identifying those areas where it could improve.

The peer review is delivered from the position of a 'critical friend' to promote sector-led improvement.

The standards are centred on the following key themes:

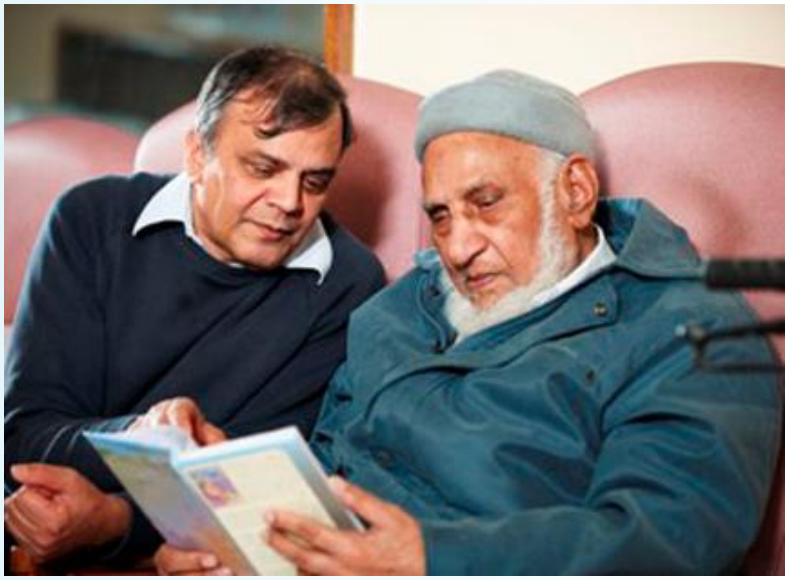
- Outcomes for and the experiences of people who use services
- Leadership, strategy and commissioning
- Service delivery, effective practice and performance and resource management
- Working together.

The Peer Challenge team members were asked to look at the Adult Safeguarding Board in the light of the requirements of the Care Act 2014. The review team members were provided with information on the Board and its subgroups for the preceding 12 months and spent three dates in Oxfordshire interviewing senior staff across all the Board partnership agencies and meeting focus groups of frontline staff, care providers and service users.

How have we responded to the national changes?

The review team felt that OSAB's strengths were:

- **Culture** – the Board member agencies were noted has having an open culture of working together on various levels.
- **Transparency** – the review team were impressed with how open and honest the professionals they met were
- **Evidence of innovation and good practice** – the Board had undertaken work to improve itself and use good practice from other areas to strengthen itself.
- **Commitment to continuous improvement**
- **Ability to deliver change** – the seniority of the Board members, their commitment to improving and the new programmes the Board was planning assured the review team that the Board had the ability to deliver the changes required.



How have we responded to the national changes?

The areas for development identified by the team were:

- **Governance** – It was recommended that the governance arrangements of the Board and its subgroups should be reviewed to ensure all statutory duties are clearly owned. The review also recommended work on the Board's relationship with other partnership groups, such as the Health & Wellbeing Board and the Community Safety Partnerships.
- **Vision, strategic plan and work programme** – The Board had not developed a strategic plan or a clear work programme at the time of the review. This has now been addressed.
- **Evidence** – The team found that the Board received a limited dataset. They recommended further development of multi-agency data and auditing processes.
- **Ensuring consistent practice** – The review recommended the development of a clear thresholds document for Oxfordshire, detailing what does and does not constitute a safeguarding issue that needs to be raised.
- **Capacity** – At the time of the review the Board was primarily funded by Adult Social Care with a contribution from the Clinical Commissioning Group. The review recommended a larger budget drawn from contributions across all agencies who are members of the Board.

Progress to date:

The Board produced and oversees action plan to address the areas for development. The report and action plan is also regularly scrutinised within the County Council's Management Team, led by the Head of Paid Service.

As of 31 March 2016, the two outstanding issues are the publication of this report and the development of multi-agency adult safeguarding training (due to be rolled out in late 2016).

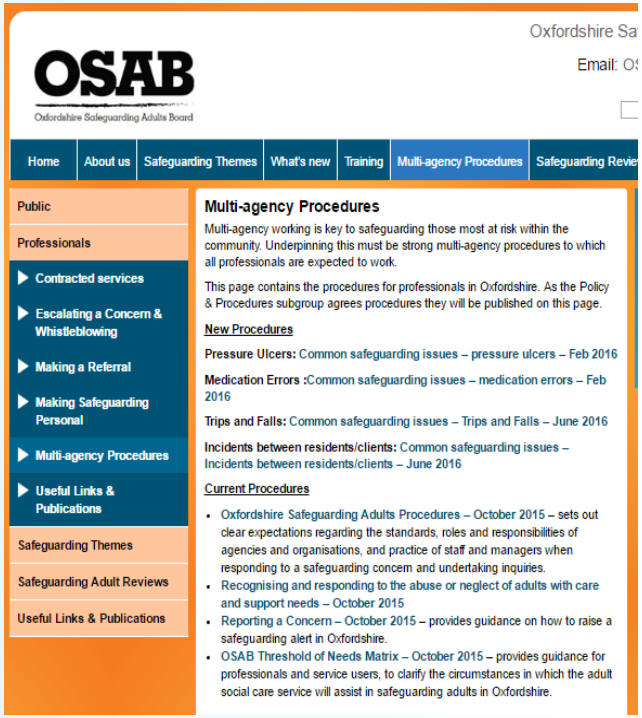
What have the subgroups been doing?
Policies and Procedures

As part of the programme to improve the Board, a new website was developed in 2015-16 . Designed to be simpler to navigate and easier to find, the new website has seen month on month increases in its use (monitored using Google Analytics). While no comparative data is available for the previous website, anecdotal feedback from professionals reports that the simplified layout makes it easier to find what you are looking for.

The Policy and Procedures subgroup of the Board has overseen a complete review of multi-agency safeguarding procedures and the thresholds document. The new manual is on the OSAB website.

The group also produced two documents focusing on common safeguarding issues; medication errors and pressure ulcers. Both were produced to help professionals make more informed judgements on when to raise a safeguarding alert.

These were produced in conjunction with the safeguarding team who helped steer the work of the group towards priority areas. In 2016-17 similar guidance will be produced for trips and falls, self-neglect and hoarding and modern slavery.



What have the subgroups been doing?
Safeguarding Adult Reviews

During 2015-16, ten cases were considered at the SAR subgroup for a possible review. Of these, three reviews were commissioned, two statutory SARs, one was a multi-agency review. None was completed before 31 March 2016, so recommendations cannot be included in this report. It is important that cases are picked up quickly and referred for consideration by the subgroup.

Connor Sparrowhawk and Mazars

Connor Sparrowhawk was a young man with learning disabilities who died in an inpatient unit in Oxford run by Southern Health NHS FT. His death was preventable. In October 2015 the Verita report into commissioning arrangements in the case of Connor Sparrowhawk was published. This was the second report into Connor's death. It focussed on whether the commissioning arrangements had a significant impact on the failures in care. The report identified specific areas of learning but found overall that the failings were in the frontline care delivery.

In December 2015 the "Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015" report was published. This report is referred to as Mazars. The report found that there had been a lack of investigation of unexpected deaths by Southern Health and very poor engagement with families.

In Oxfordshire a full review into all deaths of people with learning disabilities during the 4 year period is now being undertaken. Oxfordshire is piloting the Learning Disabilities Mortality Review (LeDeR) Programme which has been developed by the University of Bristol to look at the deaths of people with learning disabilities. In Oxfordshire the retrospective review and the LeDeR programme have led to the proposal that the Board establishes a Vulnerable Adults Mortality Review subgroup of the Adults board. This proposal is going to the June 2016 meeting.

Multi-agency Safeguarding Training

As recommended in the Peer Challenge Review, the Training Subgroup agreed to coordinate a multi-agency training programme. This has led to the development of the Training Strategy for 2016-17.

OSAB Training Strategy

The OSAB has agreed a training strategy for 2016-17 onwards. A summary is provided below

Purpose of the Strategy

The OSAB strategy is driven by the requirements laid out by the Care Act 2014, Sectors Skills Councils - Qualification Credit Framework, Care Quality Commission Safeguarding Protocol, Ofsted and the Department of Health. The OSAB training strategy will:

- Outline a framework of training to ensure that all people with contact with adults at risk receive the appropriate training required in order to fulfil their roles and responsibilities.
- Identify tools for quality assurance and effectiveness of training activities

Training Principles

The training facilitated by local providers and partners under this strategy will reflect the following principles:

- ***Adults at risk at the centre***
- ***Safeguarding adults is 'Everybody's Business'***
- ***Support performance improvement in safeguarding adults practice***

It is proposed that we will have three courses for practitioners and these will go live in 2016-17

How are we treating vulnerable people?
Dignity in Care Project

In 2015, Healthwatch Oxfordshire (HWO) partnered with Age UK Oxfordshire, the Health Experiences Institute at the University of Oxford and the Oxfordshire Association of Care providers to conduct a project into whether people in Oxfordshire felt they were being treated with dignity.

Why did Healthwatch and Age UK decide to do this piece of work?

A number of concerns about dignity in care had surfaced in several reports by community groups into experiences of their community, which were funded by and published through HWO. Similar concerns had been raised with Healthwatch by both Age UK and the Oxfordshire Rural Community Council. Healthwatch thought this project lent itself to a large-scale 'Enter and View' project. The Oxfordshire Association of Care providers wanted to work with Age UK Oxfordshire and HWO to highlight the importance of getting this right, and also to share good practice through an awards ceremony element.

Who did Healthwatch engage with and how?

The project began with a stakeholder workshop to get a better sense of what issues people had heard about dignity and what areas the project should cover. After this, a small reference group was formed in order to build interest and good will for the project, as well as to ensure that the project could function logistically. Members of this group included; Oxford University Hospitals NHS Foundation Trust, Oxford Health NHS Foundation Trust, Oxfordshire Clinical Commissioning Group, The Orders of St. John Care Trust, Oxfordshire County Council.

How are we treating vulnerable people?
Dignity in Care Project

What did Healthwatch do with our evidence?

Providers and commissioners were asked for a response to the report's findings and recommendations prior to publication. Some highlights from the commitments made for improvements include:

Oxfordshire County Council

The Council agreed to develop standards that promote dignity and are undertaking training of providers of home care to ensure staff work to this framework. Also agreed to commission an expanded advocacy service.

Oxford University Hospitals NHS Foundation Trust

OUH will also look at advocacy and training to ensure dignity and respect are fundamental to all care planning. Piloting a scheme to help increase direct contact care time, which includes a system for escalating concerns within the organisation.

Oxford Health NHS Foundation Trust:

Oxford Health will be delivering a full programme of initiatives designed to improve patient and carer involvement in planning their own care. Six-monthly review will be undertaken and reported at Board level.

What are organisations doing?
Oxfordshire County Council

Adult Social Care has a single point of contact for all referrals - the Health and Social Care Team. In 2015, we implemented a process to enable and encourage the residents of Oxfordshire to stay safe. Staff who took calls in the team asked the caller a series of questions about fire risk, people being distressed by receiving large quantities of junk mail, and distress from telephone cold calls. The information is collated and sent to either the Fire Service or Trading Standards .This has proved very successful and we intend to develop this further over 2016-17.

Adult Social Care launched the on line adult safeguarding alert form for all professionals. The benefit of the form is that it can be completed out of hours and reduces the necessity for professionals to make contact via the phone. The form includes questions directly linked to potential fire risk and issues which may necessitate Trading Standards involvement. Any information received is passed to the relevant agencies to progress.

In 2015, qualified practitioners were invited to take on the role of Making Safeguarding Personal Champion (MSP). The MSP champions' role is to support the learning/awareness of MSP in safeguarding. A MSP champion is responsible for disseminating the MSP knowledge and skills needed for all areas of work so that more workers in the sector build their confidence and understanding of MSP. Adult Social Care currently has 18 MSP champions across the county where evidence as to what has been done will be reviewed.

What are organisations doing?
Oxfordshire County Council

Meeting the Board's 2015-16 priorities

Ensure that people who use Health and Social Care services and their families are at the centre of any decisions about their care and support.

There has been significant work undertaken with individuals in receipt of direct payments to increase their understanding of making safe choices when commissioning their care and support. Updated information is now available and all staff have undertaken refresher training on direct payments. A full day workshop was organised for staff in 2015 run by Research in Practice for Adults (RIPFA) to support them in how to work collaboratively with families to ensure that they are at the centre of any decisions.

Implementation of the Peer Review Action Plan which covers governance arrangements, quality assurance and good practice issues, so that the Board is compliant with the Care Act.

In conjunction with the Quality and Contracts Team there is a quality assurance framework in place for providers. This includes a 'provider dashboard' which identifies those providers where there are concerns in respect of the quality of the care they provide. As part of the framework, Adult Social Care hold serious concerns and standards of care meetings with providers with representation from other agencies including the CQC. The purpose of the meetings is to address areas of poor quality. In November 2015, Adult Social Care launched the new IT system for all practitioners. This included the safeguarding module and the 'Making Safeguarding Personal' process.

In March 2016, the first care governance and change control meeting took place. Its function is to monitor overall performance in relation to Adult Social Care governance. It will also include discussion on the themes and trends that are identified in the reports.

What are organisations doing?
Oxfordshire Clinical Commissioning Group

The role of Oxfordshire Clinical Commissioning Group (OCCG) is to ensure the services which it commissions are delivering high quality care which safeguards vulnerable adults and children. OCCG hold providers to account through contractual mechanisms.

The CCG has oversight of the quality of commissioned services in Oxfordshire. This comprises patient safety, clinical effectiveness and patient experience. This scrutiny of health services informs the Safeguarding Adult Board. The CCG participates in Safeguarding Adult Reviews, Domestic Homicide Reviews and Mental Health Homicide Reviews.

An internal audit was carried out of the CCG's adult safeguarding function in 2015-6. The audit demonstrated standards are being met and provided assurance.

We have worked with GP practices to ensure they meet safeguarding requirements. We have assisted with policy development, education and practice development. The CCG has supported practices to fulfil the requirements of the new CQC inspection regime. These inspections have identified areas where further work is required.

The transformation of services and pressures on resources, along with the increased awareness of safeguarding will a present a considerable challenge in 2016-17. Strengthened partnership working, increased shared pathways and provision and multiagency training will be critical.

What are organisations doing?
Thames Valley Police

TVP very much recognise that there needs to be a shared approach towards achieving positive outcomes in protecting vulnerable adults and ensuring that any reports received are thoroughly and proportionately investigated. To this end; in the past year we have improved upon the training for our staff, not only within the specialist teams, but for the front line officers who are most likely to be the first responders to any reports. Training has enhanced officer's skills in investigation and safeguarding. Our SaVE training programme (Safeguarding, Vulnerability and Exploitation) has been delivered across Oxfordshire to enhance our initial response to ensure potential harm is identified at the earliest opportunity.

Domestic abuse is a thread that unfortunately effects many adults within Oxfordshire and is a priority for our Force. The development of the Domestic Abuse champions in our teams in Oxfordshire has enhanced officer's skills and provide a 'subject matter expert' within teams who can assist and guide their peers and colleagues. These individuals are afforded the opportunity to spend days with county specialist investigators in the Domestic Abuse Investigation team.

Collaborative working between the TVP specialist (DAIU) investigation team, Oxfordshire adult social care, partners and CPS has resulted in some significant serious investigations resulting in charging of offenders and prosecutions, including offences of modern day slavery, and investigations into potential neglect of duty in care homes. The partnership is strong in relation to how we work to prevent people coming to harm and to safeguard effectively when the risk is present. This is testament to our shared approach to outcomes.

The OSAB a priority for TVP, with appropriate membership at the Board and its subgroups.

What are organisations doing?
Oxford Health NHS Foundation Trust

In September 2015, OHFT was subject to a full comprehensive inspection from the Care Quality Commission. The CQC rated three domains out of the five quality domains – *caring, responsive and well led as* 'good', in the remaining two *safety and effective* were rated as 'requires improvement'. This gives an overall rating of 'Requires Improvement'. There is a full development plan in place with an aim that the safety and effective domains will become good. In 2015-16 there have been some specific areas of activity in OHFT to promote the safeguarding of patients and there is description of this activity below.

- **Historical Sexual Abuse:** A new process of being implemented to guide staff to respond effectively to people making disclosures.
- **Reducing harm from falls:** Over the last year the Older People and mental health wards have taken a series of actions to reduce the number of falls and level of harm to patients as a result of a fall.
- **Reducing Restrictive Interventions:** OHFT have a series of measure to reduce restraint to circumstances only when it is necessary for the person's safety or that of other people.
- **Reducing harm from pressure ulcers:** Prevalence of pressure damage is reducing as a result of the District Nursing Service trying different initiatives to raise awareness and improve competencies around the prevention and management of pressure ulcers.
- **Suicide:** OHFT employs a Suicide Prevention Lead Nurse. She works with the Suicide Prevention and Intervention Network (SPIN) in the Thames Valley. This includes the development of a support and co-ordination service for people bereaved or affected by suicide.

What are organisations doing?

Oxford University Hospitals NHS Foundation Trust

The team has provided safeguarding advice for 199 situations involving vulnerable adults. There have been 35 Safeguarding alerts made about Trust services. There have been 106 Deprivation of Liberties Safeguards (DOLS) applications.

Key challenges

- The rapidly growing and international nature of the safeguarding agenda for vulnerable adults; particularly surrounding modern slavery, human trafficking, FGM and the vulnerability of people from black and minority ethnic backgrounds.
- The complexity of DOLS applications and delay in assessments following the Cheshire West judgement.
- Domestic abuse and its impact on patients and staff.
- Safe and coordinated discharge of patients, particularly those who are vulnerable, require considerable family or paid carer support**.**

Key achievements

- Over 10,000 (84%) of our staff are up to date with their safeguarding training.
- The multi-agency discharge liaison hub has been developed in partnership with Oxford Health and Oxfordshire County Council. The hub enables patients previously affected by delayed transfers of care to temporarily move to a nursing home whilst a permanent package of care is finalised and put into place. This has enabled Trust staff and Care home staff to work closely together to safeguard vulnerable people.
- We have trained domestic abuse champions, learning disabilities champions and Safeguarding Leaders.
- A new Safeguarding specialist nurse has joined the team to assist with Mental Capacity Act and Prevent training.
- Partnership working with all the OSAB subgroups , MARAC and the Reducing the Risk Team.

Priorities for 2016-17

1.Empowerment

The Board will continue to work towards supporting people to manage risk in their own lives. This should be clear in all stages of Oxfordshire's safeguarding adults procedures.

There will be an emphasis on reducing focus on process and increasing focus on the individual. The Board will also ensure that there is a greater public awareness of safeguarding adults, while also managing expectations. A coordinated response is important to help increase the safety of vulnerable adults.

2. Protection

The Board will continue to work towards ensuring safeguarding adults procedures respond to abuse or neglect. We will be seeking assurance that care and support is fully compliant with the Mental Capacity Act.

This will be achieved by ensuring that there is a full range of policies, procedures and guidance in place to enable partner organisations to work together to respond to abuse and neglect. These policies, procedures and guidance will be reviewed regularly to reflect emerging developments in national guidance and legislation as well as national, regional and local learning, and new approaches to safeguarding practice. The Board will provide will provide information about what abuse and neglect is, how to recognise the signs and what they can do to prevent and then seek help and support.

Priorities for 2016-17

3.Proportionality

The Board will continue to work on ensuring that safeguarding adults policies, procedures and guidance are used in appropriate circumstances to inform a proportionate response to the concerns being raised.

This will be achieved by ensuring safeguarding adults policies, procedure and guidance are clear and explicit about the definitions and thresholds for intervention and what the potential alternatives are if these thresholds are not met. The Board will also ensure that thresholds are consistently applied by all partner agencies.

4. Prevention

The Board will seek assurance from all partner agencies that prevention is a core element in the development, commissioning and delivery of services. This includes raising awareness of the possibility of abuse ensuring staff are equipped to recognise early signs.

This will be achieved by ensuring the right people are recruited through safe recruitment mechanisms and that all staff receive appropriate training.

Strong risk management and early intervention will support those with care and support needs and reduce the risk harm.

Priorities for 2016-17

5.Partnership

The Board will develop joint working practices between and across organisations that promote coordinated, timely and effective responses for the individual at risk. The partnership aims to foster an approach that places the welfare of individuals above the needs of the system and promotes joint planning.

This will be achieved by ensuring the working relationships between partner agencies, including District Councils, are developed and sustained at a strategic and operational level and links to wider networks or Boards are clear. Learning from reviews will be shared amongst partner agencies and integrated in practice.

6. Accountability

The Board will work to ensure that the roles of all agencies and staff and their lines of accountability are clear. Agencies across the partnership will recognise their responsibilities to each other, act upon them and accept collective responsibility for safeguarding arrangements.

This will be achieved by using a self assessment framework for the Board and partner agencies. The Board will improve the performance management information available on safeguarding adults. This will include feedback from individuals who have been subject to safeguarding adults procedures. Board assurance activity will include assessing whether risk management is proportionate and coordinated.